Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ULTIMATE PAIN SOLUTION
9700 RICHMOND AVE SUITE 120
HOUSTON TX 77042

Respondent Name

ALIEF ISD

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-12-1072-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was submitted for payment and this claim was denied after the service was authorized…This patient treatment is a medical necessity and the denial of these claims is not justified."

Amount in Dispute: $13,445.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on Rule §134.600(h) Except for requests submitted in accordance with subsection (g) of this section, the carrier shall approve or deny requests based solely upon the medical necessity of the health care required to treat the injury, regardless of;(1) unresolved issues of compensability, extent of or relatedness to the compensable injury; (2) the carrier's liability for the injury; or (3) the fact that the employee has reached maximum medical improvement. The notice for preauthorization approval clearly notes' COMPENSABILITY ISSUES, DECISION BASED ON MEDICAL NECESSITY ONLY. Based on this information additional allowance is not warranted."

Response Submitted by: Alief ISD PO Box 672447 Houston TX 77267

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2011 through October 24, 2011	97110, 97140, 97112, 99214, 99070, 97545-WH, 97546-WH, 90801, and 99080-73	$13,445.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review

Conference.

4. This request for medical fee dispute resolution was received by the Division on December 7, 2011.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 4, 2011 and November 22, 2011

   - 219 BASED ON EXTENT OF INJURY
   - 1014 THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT, THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED
   - 5053 TREATMENT IS NOT RELATED TO ORIGINAL WORK INJURY.
   - 16 CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
   - B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
   - W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 170 PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER.
   - 812 CHARGES DENIED BECAUSE THIS PROVIDER IS APPROVED FOR NON-MEDICAL MANAGEMENT PROCEDURES ONLY AND/OR IS PROVIDING SERVICES RESTRICTED BY HIS/HER LICENSING BOARD.
   - 5066 THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 5043 28 TAC SECTOPM 133.20 (E)(2) STATES A MEDICAL BILL MUST BE SUBMITTED' IN THE NAME OF THE LICENSED HEALTH CARE PROVIDER THAT PROVIDED THE HEALTH CARE OR THAT PROVIDED DIRECT SUPERVISION OF AN UNLICENSED INDIVIDUAL WHO PROVIDED THE HEALTH CARE.
   - 296 SERVICE EXCEEDS MAXIMUM REIMBURSEMENT GUIDELINES.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.305(b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.
2. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution.
3. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 22, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.